

## Release of Special Education Information for Medicaid Billing Purposes--18 Year Old Student

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medicaid Number (optional): \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

\_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

I give consent to my school district for the release of special education evaluations, IEPs, and Medicaid claims documents to:

- A physician or nurse practitioner in order for him/her to reach a determination that the services are medically necessary; and
- Individuals within the Department of Education and the Agency of Human Services (AHS) charged with processing Medicaid bills for medical services included in my IEP.

The school district will only release the records essential for billing purposes and the above individuals will only review the documents necessary to perform their assigned tasks in the Medicaid billing process.

Consent to the release of information is voluntary. I understand that if I refuse to give consent, my refusal will only affect the **billing** for IEP medical services to Medicaid; my refusal does not relieve the school district of its responsibility to provide IEP services at no cost to me. I understand that I may revoke this consent to release information for Medicaid billing at any time; if I revoke this consent, it will apply to billing for services from that date forward.

Check one:

\_\_\_\_\_ I **authorize** the school district to release this information.

\_\_\_\_\_ I **do not authorize** the school district to release this information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_